



Send completed forms
to DOH Communicable
Disease Epidemiology
Fax: 206-418-5515

LHJ Use ID _____
☐ Reported to DOH Date ____/____/____
LHJ Classification ☐ Confirmed
☐ Probable
By: ☐ Lab ☐ Clinical
☐ Other: _____
Outbreak # (LHJ) _____ (DOH) _____

DOH Use ID _____
Date Received ____/____/____
DOH Classification
☐ Confirmed
☐ Probable
☐ No count; reason: _____

Yellow Fever

County _____

REPORT SOURCE

Initial report date ____/____/____

Reporter (check all that apply)

☐ Lab ☐ Hospital ☐ HCP

☐ Public health agency ☐ Other

OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation
start date:
____/____/____

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____

Address _____ ☐ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Phone _____

Name _____

Occupation/grade _____

Employer/worksite _____ School/child care name _____

Birth date ____/____/____ Age _____

Gender ☐ F ☐ M ☐ Other ☐ Unk

Ethnicity ☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race (check all that apply)

☐ Amer Ind/AK Native ☐ Asian

☐ Native HI/other PI ☐ Black/Afr Amer

☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ____/____/____ ☐ Derived Diagnosis date: ____/____/____ Illness duration: _____ days

Signs and Symptoms

Y N DK NA

☐ ☐ ☐ ☐ **Fever** Highest measured temp: ____ °F
Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk

☐ ☐ ☐ ☐ **Chills**

☐ ☐ ☐ ☐ **Headache**

☐ ☐ ☐ ☐ **Muscle aches or pain (myalgia)**

☐ ☐ ☐ ☐ Back ache

☐ ☐ ☐ ☐ Confusion

☐ ☐ ☐ ☐ Prostration

☐ ☐ ☐ ☐ Nausea

☐ ☐ ☐ ☐ Vomiting

Predisposing Conditions

Y N DK NA

☐ ☐ ☐ ☐ Viral encephalitis in past (e.g. dengue, SLE, WNV)

☐ ☐ ☐ ☐ Neonatal

Delivery location: _____

☐ ☐ ☐ ☐ Pregnant

Estimated delivery date ____/____/____

OB name, address, phone: _____

Clinical Findings

Y N DK NA

☐ ☐ ☐ ☐ Prostration

☐ ☐ ☐ ☐ Slow weak pulse

☐ ☐ ☐ ☐ **Hepatitis**

☐ ☐ ☐ ☐ **Jaundice**

☐ ☐ ☐ ☐ Liver failure

☐ ☐ ☐ ☐ Renal abnormality or failure

☐ ☐ ☐ ☐ Hemorrhagic symptoms

☐ Epistaxis ☐ Gingival bleeding

☐ Hematemesis ☐ Melena

☐ Other: _____

☐ ☐ ☐ ☐ Shock

Hospitalization

Y N DK NA

☐ ☐ ☐ ☐ Hospitalized for this illness

Hospital name _____

Admit date ____/____/____ Discharge date ____/____/____

Y N DK NA

☐ ☐ ☐ ☐ Died from illness Death date ____/____/____

☐ ☐ ☐ ☐ Autopsy Place of death _____

Vaccinations

Y N DK NA

☐ ☐ ☐ ☐ Yellow fever or Japanese encephalitis vaccine in past

Laboratory

P = Positive O = Other, unknown
N = Negative NT = Not Tested
I = Indeterminate

Collection date ____/____/____

P N I O NT

☐ ☐ ☐ ☐ ☐ **Yellow fever antibodies with 4-fold rise (acute and convalescent serum pair) with no recent history of yellow fever vaccination and no cross reaction with other flaviviruses**

☐ ☐ ☐ ☐ ☐ **Yellow fever virus, genome or antigen (tissue, blood or other body fluid)**

☐ ☐ ☐ ☐ ☐ **Albuminuria**

☐ ☐ ☐ ☐ ☐ Leukopenia

NOTES

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count backward to determine probable exposure period

Days from onset:

Exposure period

-6

-3

o
n
s
e
t

Calendar dates:

EXPOSURE (Refer to dates above)

Y N DK NA

- ☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Dates/Locations: _____

- ☐ ☐ ☐ ☐ Case knows anyone with similar symptoms
☐ ☐ ☐ ☐ If infant, birth mother had febrile illness
☐ ☐ ☐ ☐ If infant, confirmed infection in birth mother
☐ ☐ ☐ ☐ If infant, breast fed

Y N DK NA

- ☐ ☐ ☐ ☐ In area with mosquito activity
Date/Location: _____
Remember mosquito bite ☐ Y ☐ N ☐ DK ☐ NA
Date/Location: _____
☐ ☐ ☐ ☐ Outdoor or recreational activities (e.g. lawn mowing, gardening, hunting, hiking, camping, sports, yard work)
☐ ☐ ☐ ☐ Employed in laboratory
☐ ☐ ☐ ☐ Blood transfusion or blood products (e.g. IG, factor concentrates)
Date of receipt: __/__/__
☐ ☐ ☐ ☐ Organ or tissue transplant recipient
Date of receipt: __/__/__
☐ ☐ ☐ ☐ Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____

☐ Patient could not be interviewed

☐ No risk factors or exposures could be identified

Most likely exposure/site: _____

Site name/address: _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PUBLIC HEALTH ISSUES

Y N DK NA

- ☐ ☐ ☐ ☐ Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset Date: __/__/__
Agency and location: _____
Specify type of donation: _____
☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

- ☐ Breastfeeding education provided
☐ Notify blood or tissue bank
☐ Other, specify: _____

NOTES

Investigator _____ Phone/email: _____

Investigation complete date __/__/__

Local health jurisdiction _____

Record complete date __/__/__